

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

31873

3835

SEP 20 1952

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>		c. LENGTH OF STAY (In this place) <u>5 MONTHS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL SMITHVILLE</u>		0240	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4208 HARRISON STREET</u>				d. STREET ADDRESS (If rural, give location) <u>R.R.</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>ARTHUR</u>		b. (Middle) <u>SMITH</u>		c. (Last)	
4. DATE OF DEATH		a. (Month) <u>AUGUST</u>		b. (Day) <u>26</u>		c. (Year) <u>1952</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JUNE 24 1868</u>	9. AGE (In years last birthday) <u>84</u>	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 1 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - PATTERN MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>GAINSBOROUGH ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>ROBERT D. SMITH</u>		13b. MOTHER'S MAIDEN NAME <u>ANNIE SLEIGHT</u>		14. NAME OF HUSBAND OR WIFE <u>ANNIE SMITH</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS. ANNIE SMITH 4208 HARRISON ST. KANSAS CITY, MO.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis (Cerebral)</u> DUE TO (c) <u>Arteriosclerosis (Generalized)</u> 14% II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Spidial Decompensation - Chronic</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		332X	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 5</u> , 1952, to <u>Aug 26</u> , 1952, that I last saw the deceased alive on <u>Aug 26</u> , 1952, and that death occurred at <u>1:00 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Carl R. Ferris</u> (Degree or title) <u>MD</u>		23b. ADDRESS <u>934 Maple St. Kansas City, Mo.</u>		23c. DATE SIGNED <u>8-27-52</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 29, 1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>	
DATE REC'D BY LOCAL REG. <u>8-29-52</u>		REGISTRAR'S SIGNATURE <u>Deraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>D. H. Newcomer 1331 BRUSH CREEK KANSAS CITY, MO.</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Charles H. Stishny

Licensed Embalmer No. 45600

P. O. Address. KP Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.